Woodview Medical Centre

26 Holmecross Road
Thorplands
Northampton
NN3 8AW

New Patient Application Form

(Please complete a separate form for each member of the family)

Title	**Date of Birth**			
First Name	**Surname (Family Name)**			
Occupation	**Previous Surnames**			
Current Home Address	**Home Telephone Number**			
	Work Telephone Number			
	Mobile Telephone Number			
	Email address			
Post Code	**NHS Number if known**			
Name and address of your previous GP/Practice	**Please tick here if you have never been registered with a GP**			
How long do you intend to live at your new address?	**Less than 6 months**		**More than 6 months**	
If you are new to the UK please give date of entry				
Next of Kin Details	**Name**			
	Address			
	Telephone Number			
	Relationship			

Do you have, or have you ever had a Social Worker involved in your family (please tick)	**Yes**
	No
	Do not want to answer

Please tick which documents you have provided as proof of your Identity

Passport		**Photo Driving Licence**	
Birth Certificate		**Other (Please state)**	

Please tick which documents you have provided as proof of your address

Utility Bill		**Official Letter**	
Bank Statement		**Other (Please state)**	

If you are new to the UK have you provided proof of UK residency?

Passport/Visa	**Yes**	**No**

For patients under 18 only

Do you have, or have you ever had a Social Worker involved with your family	**Yes**	**No**
Please provide the name of the school/nursery attended		

<u>Ethnic Origin</u> – Please tick appropriate box

This information will help to plan services to meet the needs of all patients

White	British		Irish		Other		Other white background	
Black	Caribbean		African		Other		Other Black background	
Asian	Indian		Pakistani		Bangladeshi		Other Asian background	
Mixed	White and black Caribbean		White and black African		White and Asian		Other Mixed Background	
Other Ethnicity	Chinese		Other					
Ethnic Category Not Stated								
What is your first language?								

Medical Information

Smoking

Smoker – How many cigarettes smoked a day?	**Number:**
Past Smoker – When did you give up?	**Date:**
Never Smoked	**Please tick:**

Carers

Do you care for someone?	**Yes**	**No**	
If Yes Please give details	**Name:**		**Relationship:**
Does someone care for you?	**Yes**	**No**	
If Yes Please give details	**Name:**		**Relationship:**

Please list any serious illness, operations or disabilities YOU have

Details	**Year**

Family History

Please tick if anyone in your close family (i.e. parents, bother and sisters) have suffered from any of the following:

	Relative	**Age at onset**		**Relative**	**Age at onset**
Angina			**Eczema**		
Asthma			**Epilepsy**		
Blindness/ Glaucoma			**Hayfever**		
Breast Cancer			**Heart Attack**		
Other Cancer			**High Blood Pressure**		
COPD			**Sickle Cell**		
Depression			**Stroke**		
Diabetes			**Thalassaemia**		

Mobility

Are you housebound?	**Yes**	**No**

Recent Blood Pressure

Blood pressure Reading /	**Date taken**

Allergies

Do you have any allergies?	**Yes**	**No**	**Please give details:**
Are you allergic to any medicines	**Yes**	**No**	**Please give details:**

Current Medication

Please list:

Other Information

Are you registered disabled?	**Yes**	**No**

Summary Care Record

The NHS in England is introducing the summary Care Record which will be used in emergency care. The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely. The information will be taken from your GP record.

As a patient you have a choice - please indicate below

Yes I would like a summary care record	
No I do not want a summary care record	

If you require further information about making your choice please ask at reception.

Signature _____

Parent /Guardian: _____ **(if applicable)**

Date: _____